

		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0045476</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER													
Facility Name: <u>Red Bud Nursing Home</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.													
Address: <u>350 W South 1st Street</u> <u>Red Bud</u> <u>62278</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.													
County: <u>Randolph</u>															
Telephone Number: <u>(618) 282-3831</u> Fax # <u>(618) 282-4070</u>															
IDPA ID Number: <u>364443918001</u>															
Date of Initial License for Current Owners: <u>09/01/01</u>															
Type of Ownership:															
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY													
<input type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual													
<input type="checkbox"/> Trust		<input type="checkbox"/> State													
IRS Exemption Code _____		<input type="checkbox"/> Partnership													
		<input checked="" type="checkbox"/> Corporation													
		<input type="checkbox"/> "Sub-S" Corp. _____													
		<input type="checkbox"/> Limited Liability Co. _____													
		<input type="checkbox"/> Trust													
		<input type="checkbox"/> Other _____													
In the event there are further questions about this report, please contact: Name: <u>Richard D. White</u> Telephone Number: <u>(618) 282-3831</u>		<table border="1"> <tr> <td rowspan="2"> Officer or Administrator of Provider </td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="4"> Paid Preparer </td> <td>(Type or Print Name) <u>Richard D. White</u></td> </tr> <tr> <td>(Title) <u>Chief Financial Officer</u></td> </tr> <tr> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td></td> <td> (Print Name and Title) <u>Roger Greenup, CPA</u> <u>Shareholder</u> (Firm Name & Address) <u>Horne CPA Group</u> <u>1801 West End Avenue, Ste. 800, Nashville, TN 37202-3129</u> (Telephone) <u>(615) 312-9050</u> Fax # <u>(615) 312-9100</u> </td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Richard D. White</u>	(Title) <u>Chief Financial Officer</u>	(Signed) _____	(Date) _____		(Print Name and Title) <u>Roger Greenup, CPA</u> <u>Shareholder</u> (Firm Name & Address) <u>Horne CPA Group</u> <u>1801 West End Avenue, Ste. 800, Nashville, TN 37202-3129</u> (Telephone) <u>(615) 312-9050</u> Fax # <u>(615) 312-9100</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Officer or Administrator of Provider	(Signed) _____														
	(Date) _____														
Paid Preparer	(Type or Print Name) <u>Richard D. White</u>														
	(Title) <u>Chief Financial Officer</u>														
	(Signed) _____														
	(Date) _____														
	(Print Name and Title) <u>Roger Greenup, CPA</u> <u>Shareholder</u> (Firm Name & Address) <u>Horne CPA Group</u> <u>1801 West End Avenue, Ste. 800, Nashville, TN 37202-3129</u> (Telephone) <u>(615) 312-9050</u> Fax # <u>(615) 312-9100</u>														
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630															

Facility Name & ID Number Red Bud Nursing Home# 0045476 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>115</u>	Skilled (SNF)	<u>115</u>	<u>41,975</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>115</u>	TOTALS	<u>115</u>	<u>41,975</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>3,882</u>	<u>1,885</u>	<u>353</u>	<u>6,120</u>	8
9	SNF/PED					9
10	ICF	<u>20,460</u>	<u>11,502</u>		<u>31,962</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>24,342</u>	<u>13,387</u>	<u>353</u>	<u>38,082</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 90.73%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 09/01/01

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 09/01/01 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified 20 and days of care provided 353Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	160,573	106,895	120,631	388,099	33,615	421,714	358,435	780,149		1
2	Food Purchase										2
3	Housekeeping	97,804	7,381		105,185		105,185		105,185		3
4	Laundry	56,070	31,941	(24,413)	63,598	(1,934)	61,664		61,664		4
5	Heat and Other Utilities			78,436	78,436		78,436		78,436		5
6	Maintenance			3,562	3,562	9,145	12,707	546	13,253		6
7	Other (specify):*		61,409	(352)	61,057		61,057		61,057		7
8	TOTAL General Services	314,447	207,626	177,864	699,937	40,826	740,763	358,981	1,099,744		8
	B. Health Care and Programs										
9	Medical Director										9
10	Nursing and Medical Records	1,356,113	9,787	169,767	1,535,667	(38,078)	1,497,589	(158)	1,497,431		10
10a	Therapy	11,351	9	5,971	17,331		17,331		17,331		10a
11	Activities	43,904	1,745	5,265	50,914	(1,738)	49,176	(1,555)	47,621		11
12	Social Services	38,626		215	38,841	(18)	38,823		38,823		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,449,994	11,541	181,218	1,642,753	(39,834)	1,602,919	(1,713)	1,601,206		16
	C. General Administration										
17	Administrative	125,455	1,889	104,953	232,297	(37,470)	194,827	971,780	1,166,607		17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions			6,645	6,645		6,645		6,645		20
21	Clerical & General Office Expenses			8,426	8,426		8,426		8,426		21
22	Employee Benefits & Payroll Taxes			518,481	518,481		518,481	(244,680)	273,801		22
23	Inservice Training & Education										23
24	Travel and Seminar					1,867	1,867		1,867		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			3,016	3,016		3,016		3,016		26
27	Other (specify):*			(58,593)	(58,593)		(58,593)	58,761	168		27
28	TOTAL General Administration	125,455	1,889	582,928	710,272	(35,603)	674,669	785,861	1,460,530		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,889,896	221,056	942,010	3,052,962	(34,611)	3,018,351	1,143,129	4,161,480		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Red Bud Nursing Home

#0045476

Report Period Beginning: 01/01/03 Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			22,555	22,555		22,555	15,842	38,397			30
31	Amortization of Pre-Op. & Org.			28	28		28		28			31
32	Interest											32
33	Real Estate Taxes			10,384	10,384		10,384		10,384			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					8,342	8,342		8,342			35
36	Other (specify):*					7,660	7,660		7,660			36
37	TOTAL Ownership			32,967	32,967	16,002	48,969	15,842	64,811			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops					18,609	18,609		18,609			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			62,963	62,963		62,963		62,963			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			62,963	62,963	18,609	81,572		81,572			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,889,896	221,056	1,037,940	3,148,892		3,148,892	1,158,971	4,307,863			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(1,983)	17		18
19 Entertainment	(143)	10		19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers	(1,848)	17		22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	58,761	27		24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule				29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ 54,787		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	1,109,839		34
35 Other- Attach Schedule	15,842	30	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 1,125,681		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 1,180,468		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

Red Bud Nursing Home

ID# 0045476

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Entertainment	\$ (15)	10	1
2	Entertainment	(339)	17	2
3	Entertainment	(1,555)	11	3
4	Flowers, Gifts	(18,303)	17	4
5	Entertainment, Flowers, Gifts	(1,285)	17	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(21,497)		49

Summary A

12/31/03

12/31/03

[illegible]

Summary B

12/31/03

[illegible]

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Community Health	100%			Red Bud Hospital	Red Bud, IL	Hospital
155 Franklin Road				P.A.S.I.		Colletions
Brentwood, TN 37027				See Home Office Cost Report for complete listing of CHS entities		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	22 Employee Benefits	\$ 518,481	Red Bud Hospital	100.00%	\$ 273,801	\$ (244,680) 1
2	V	17 Admin & General		Red Bud Hospital	100.00%	995,538	995,538 2
3	V	1 Dietary		Red Bud Hospital	100.00%	626,532	626,532 3
4	V	1 Cafeteria	388,099	Red Bud Hospital	100.00%	120,002	(268,097) 4
5	V						5
6	V	6 Maintenance		Red Bud Hospital	100.00%	546	546 6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 906,580			\$ 2,016,419	\$ * 1,109,839 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Red Bud Nursing Home # 0045476 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Charlie Mudd		Board of Dir & NH Barber	0.00	0			Barber	\$ 1,635	40, Col 5	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,635		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Red Bud Nursing Home# 0045476

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Community Health Systems

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	22	Employee Benefits	Gross Salaries	2	\$ 1,133,952	\$ 97,357	1,889,896	\$ 273,801	1
2	17	Admin & General	Accumulated Costs	2	3,699,579	897,677	3,207,655	995,538	2
3	1	Dietary	Meals Served	2	1,101,257	266,061	126,031	626,532	3
4	1	Cafeteria	FTEs	2	302,623	0	7,884	120,002	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15		NOTE: Red Bud Hospital's services provided to NH are allocated to NH through cost finding in the hospital cost report. Col. 2-6 are from WS B-1 of Red Bud Hospital's FY 03 Medicare cost report. Col 7 is W/S A Salaries only (including A-6 reclassifications and A-8 adjustments). Col 8 is from Red Bud Nursing Home data for the fiscal year ended 12/31/03.							15
16									16
17									17
18									18
19									19
20									20
21		NOTE: Cafeteria salaries are calculated from Dietary. No other overhead allocation of salaries is included in col. 7.							21
22									22
23									23
24									24
25	TOTALS				\$ 6,237,411	\$ 1,261,095		\$ 2,015,873	25

Facility Name & ID Number Red Bud Nursing Home# 0045476

Report Period Beginning:

01/01/03

Ending:

12/31/03**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	N/A						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

B. Real Estate Taxes

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>			
1. Real Estate Tax accrual used on 2002 report.	\$	10,394	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	10,394	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	10,384	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.			
TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	10,384	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	8	
	1999	9	
	2000	10	
	2001	11	
	2002	12	

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Red Bud Nursing Home COUNTY Randolph

FACILITY IDPH LICENSE NUMBER 0045476

CONTACT PERSON REGARDING THIS REPORT Richard D. White

TELEPHONE (619) 282-3831 FAX #: ()

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>13-095-003-00</u>	<u>See attached documentation</u>	<u>\$ 41,576.00</u>	<u>\$ 10,394.14</u>
2.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
3.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
4.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
5.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
6.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
7.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
8.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
9.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
10.	<u> </u>	<u> </u>	<u>\$</u>	<u>\$</u>
		TOTALS	\$ <u>41,576.00</u>	\$ <u>10,394.14</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:

32,821

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

1

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Red Bud Hospital: 123,895 square feet, attached but a separate building

Red Bud Hospital is a hospital with 41 acute beds, 6 ICU beds, and 40 long term care beds, including 16 which are Medicare certified as SNF beds.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2					2
3	TOTALS			\$	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	2 FOR OHF USE ONLY	3 Year Acquired	4 Year Constructed	5 Cost	6 Current Book Depreciation	7 Life in Years	8 Straight Line Depreciation	9 Adjustments	10 Accumulated Depreciation	
4	115		2001	1975	\$ 724,551	\$ see attached schedule		\$	#VALUE!	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nursing Home was acquired 09/01/01.										9
10											10
11	Refer to attached schedule for building improvements after 9/1				85,469						11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 810,020	\$		\$	\$ #VALUE!	\$	70

**Improvement type must be detailed in order for the cost report to be considered complete

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 670,068	\$ See attached	\$ See attached	\$ #VALUE!		\$ See attached	71
72	Current Year Purchases	2,090	See attached	See attached	#VALUE!		See attached	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 672,158	\$	\$	\$ #VALUE!		\$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$ 7,133	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$ 7,133	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,489,311	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ #VALUE!	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land Improvements	\$ 3,594	\$ see attached	\$ see attached	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 3,594	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Ending: 12/31/03

A. Building and Fixed Equipment (See instructions.)

If NO, see instructions.

☐ NO

12.	<u> </u>	<u>/2004</u>	\$ <u> </u>
13.	<u> </u>	<u>/2005</u>	\$ <u> </u>
14.	<u> </u>	<u>/2006</u>	\$ <u> </u>

(Attach a schedule detailing the breakdown of movable equipment)

**** This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

1		2		3		4		5		6		7		8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1					
2	Licensed Speech and Language Development Therapist	10a, Col 3	hrs		109	5,971		109	5,971	2					
3	Licensed Recreational Therapist		hrs							3					
4	Licensed Physical Therapist	10a, Col 1	93.75 hrs	2,683				94	2,683	4					
5	Physician Care		visits							5					
6	Dental Care		visits							6					
7	Work Related Program		hrs							7					
8	Habilitation		hrs							8					
9	Pharmacy		# of prescripts							9					
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10					
11	Academic Education		hrs							11					
12	Exceptional Care Program									12					
13	Other (specify):									13					
14	TOTAL			\$ 2,683	109	\$ 5,971	\$	202	\$ 8,654	14					

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (87,578)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (24,820))	267,537		3
4	Supply Inventory (priced at)	19,334		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	3,339		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 202,632	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,244		13
14	Buildings, at Historical Cost	314,751		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	132,558		16
17	Accumulated Depreciation (book methods)	(57,971)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): MIS Charges	100		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 390,682	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 593,314	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 34,325	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	149,789		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Liabilities	31,256		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 215,370	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Accounts	(1,323,075)		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ (1,323,075)	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ (1,107,705)	\$	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,701,019	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 593,314	\$	48

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,238,161	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,238,161	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	462,857	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 462,857	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,701,018	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Red Bud Nursing Home

0045476

Report Period Beginning: 01/01/03

Ending:

12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 3,939,330	1
2	Discounts and Allowances for all Levels	(354,885)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,584,445	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	20,765	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	261	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,280	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 27,306	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,611,750	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services		31
32	Health Care	(3,148,894)	32
33	General Administration		33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ (3,148,894)	40
41	Income before Income Taxes (line 30 minus line 40)**	462,856	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 462,856	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Red Bud Nursing Home

0045476

Report Period Beginning: 01/01/03

Ending:

12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,920	2,008	\$ 52,290	\$ 26.04	1
2	Assistant Director of Nursing	916	1,096	27,068	24.70	2
3	Registered Nurses	7,784	8,361	197,718	23.65	3
4	Licensed Practical Nurses	18,209	20,148	297,771	14.78	4
5	Nurse Aides & Orderlies	65,906	72,766	767,478	10.55	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	141	141	3,986	28.27	7
8	Rehab/Therapy Aides	671	681	7,365	10.81	8
9	Activity Director	1,897	2,214	25,703	11.61	9
10	Activity Assistants	2,060	2,152	18,202	8.46	10
11	Social Service Workers	3,591	4,107	38,626	9.40	11
12	Dietician					12
13	Food Service Supervisor	1,357	1,491	16,716	11.21	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,215	18,379	143,857	7.83	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	12,525	13,711	97,804	7.13	18
19	Laundry	6,134	7,463	56,070	7.51	19
20	Administrator	1,892	2,068	64,558	31.22	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,074	5,510	56,923	10.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,306	1,687	17,761	10.53	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	148,598	163,983	\$ 1,889,896 *	\$ 11.52	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director		5,000	17, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,750	10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,415		44
45	Social Service Consultant				45
46	Other(specify) Risk Mgt	16	2,771		46
47					47
48					48
49	TOTAL (lines 35 - 48)	58	\$ 11,936		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	92	\$ 3,038	10, Col 3	50
51	Licensed Practical Nurses	1,366	41,952	10, Col 3	51
52	Nurse Aides	4,137	76,641	10, Col 3	52
53	TOTAL (lines 50 - 52)	5,595	\$ 121,630		53

Facility Name & ID Number **Red Bud Nursing Home**# **0045476**Report Period Beginning: **01/01/03**Ending: **12/31/03****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description			Description		
Barbara Mertz	Administrator	0	\$ 64,558	Workers' Compensation Insurance	\$ 50,453		IDPH License Fee	\$	
				Unemployment Compensation Insurance	38,654		Advertising: Employee Recruitment		
				FICA Taxes	137,475		Health Care Worker Background Check		
				Employee Health Insurance	277,332		(Indicate # of checks performed _____)		
				Employee Meals			L.S.N. (7381-423)	3,740	
				Illinois Municipal Retirement Fund (IMRF)*			Newspaper & Magazine sub (7371-423)	371	
				Employee Ins - Vision	422		Newspaper & Magazine sub (7381-423)	136	
				Employee Ins - Life	2,131		Newspaper Advertising (7381,7371-372)	2,044	
				Employee Ins - Other	1,054		Other Marketing (7381-390)	255	
				Retirement Plan Contributions	9,348		Other Adv (7381.379)	100	
				Other Employee Benefits	1,612		Less: Public Relations Expense	()	
							Non-allowable advertising	()	
							Yellow page advertising	()	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 64,558	TOTAL (agree to Schedule V, line 22, col.8)		\$ 518,481	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 6,646
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description		Amount
Purchased services, contract labor, & other operating expenses			\$ 59,478			\$	Out-of-State Travel	\$	
Physician/consulting			33,816						
Maintenance, repair, leased equipment (see reclasses, adj)			10,583				In-State Travel		926
Travel, meals, entertainment, education (see reclasses, adj)			1,076						
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 104,953				Seminar Expense		941
C. Professional Services				TOTAL			Entertainment Expense ()		
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)		
Various - see attached invoices	Legal Fees		\$ 25,737				TOTAL		
							\$ 1,867		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 25,737						

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

Facility Name & ID Number Red Bud Nursing Home

STATE OF ILLINOIS

0045476

Report Period Beginning:

01/01/03

Ending:

Page 23

12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. L.S.N. \$ 3,740
- (3) Did the nursing home make political contributions or payments to a political organization? no If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? see attached wkps
What was the average life used for new equipment added during this period? see attached wkps
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 29,057 Line 7, Col 2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over _____
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 62,963
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? n/a
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ n/a Has any meal income been offset against related costs? yes Indicate the amount. \$ see MC cost report
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ n/a
- c. What percent of all travel expense relates to transportation of nurses and patients? n/a
- d. Have vehicle usage logs been maintained? n/a
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
- g. Does the facility transport residents to and from day training? no**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ n/a
- (17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: not separately audited; part of a chain The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? n/a If no, please explain. n/a
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.